TESTIMONY OF
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SUBMITTED TO THE
INSURANCE AND REAL ESTATE COMMITTEE
Thursday, March 17, 2022

HB 5447, An Act Concerning Prior Authorization For Health Care Provider Services

Stamford Health appreciates this opportunity to submit testimony concerning **HB 5447, An Act Concerning Prior Authorization For Health Care Provider Services.** Stamford Health supports legislative action to address serious problems with the conduct of prior authorization; however, this bill as written does not protect patients or their providers.

Stamford Health is a comprehensive, independent, non-profit system serving lower Fairfield and Westchester counties. We employ more than 3,700 people, making us the largest employer in the city of Stamford and one of the largest in Fairfield County. Beyond the lifesaving care we provide 24 hours a day, 365 days a year, we contribute more than $1 billion to our state and local economy and provide more than $90 million in uncompensated care to the residents that need it most. We are committed to providing friendly, personal care coupled with the most sophisticated services to residents.

Private health insurance is the source of coverage in the employer-sponsored, small group, and individual insurance markets. Nearly all private health plan coverage arrangements, whether commercial or Medicare Advantage, rely on utilization management, and specifically prior authorization, as a means to gate-keep access to medically necessary services.

Today, aggressive prior authorization is common throughout the industry. Health plans are using prior authorization to restrict access to patients' covered services. Moreover, they are continually changing the rules that govern prior authorization, often in the middle of provider-insurer contract periods. While the stated intent of prior authorization is to help ensure patients receive care that is safe, efficacious, and beneficial to the individual patient, we have observed that many health plans are applying prior authorization requirements in ways that impact care.

Frequently, health plans establish different requirements for the information a provider must include in a prior authorization request for a particular covered benefit, and health plans often change those requirements unilaterally throughout a contract term.

Delays are most common when patients come in after hours or on weekends when most health plans do not have staff available to review routine requests. Keeping a patient in the emergency department or an inpatient bed while waiting for a plan's decision or response to a prior authorization request is not in the best interest of the patient. We strive to ensure that patients are receiving the right level of care when they need it. When patients wait for transfer to settings that focus on both medical and rehabilitative needs, their progress toward recovery can be negatively affected.

During a time of national emergency where workforce shortages and strained health system capacity have been persistent challenges, there is simply insufficient bandwidth to comply with such cumbersome administrative procedures. Hospitals often have multiple full-time employees whose sole role is to manage health plan prior authorization requests. Prior authorization processes exacerbate workforce challenges and contribute to physician and other staff burnout. Expending staff resources to respond to health plan administrative requirements is unreasonable at any time, and far worse as we confront unprecedented and likely enduring challenges recruiting and retaining essential healthcare workers.

We urge the Committee to not simply study the issue but to enact real prior authorization reform this session.

Thank you for your consideration of our position.